



VOLUNTEER APPLICATION

Name of Applicant _____ Birthdate _____
Please print

Address _____
Street City/State Zip Code

Home Phone _____ Cell Phone _____ Work Phone _____

E-mail _____ Can receive calls at work: Yes No
Emergency Only

Social Security No. _____

Have you ever been convicted of a felony/misdemeanor? If yes, please explain

Person to be notified in case of an emergency

Name _____ Phone: _____
Home _____ Business _____

Address _____
Name of Business/Street/Apt. or Suite # City OK Zip Code

Education/Special Training

Work Experience

Personal References Please list two people whom we may contact (excluding family members).

Name _____

Address _____
Name of Business/Street/Apt. or Suite # City OK Zip Code

Home Phone _____ Business
Phone _____ Cell _____
Name _____

Address _____
Name of Business/Street/Apt. or Suite # City OK
Zip Code

Home Phone _____ Business
Phone _____ Cell _____

Identified areas of interest:

**Direct Patient/Family Care
Services Cont'd.**

____ Companionship/Visits

____ Internship - Pastoral
____ Photography

----- Internship - Nursing
Albums

____ Errands/Shopping

____ Writing/Recording
Therapy
Patient's Life Story

____ Other _____

Indirect Services

____ Community/Public

____ Administrative/Office

----- Crafts/Sewing/Knitting ----- Picture

____ Pet Therapy

____ Fundraising

Indirect

____ Hospitality

____ Music Therapy

____ Massage

Are you fluent in a language other than English?

Language _____ Speak Read Write
Language _____ Speak Read Write

Other special services: (manicurist, hairdresser, printer, etc.)

Do you have access to transportation? Yes No

Availability for Volunteer Services:

Weekdays Weekends Evenings Mornings Afternoons

How did you hear about the Seasons Hospice Volunteer Program?

Why do you want to be a hospice volunteer?

What qualities (skills, talents, knowledge, certifications, license, and experiences) do you feel you can incorporate into your hospice volunteer work?

Has someone close to you died with the past year? Yes No
If yes, please explain:

FOR DIRECT PATIENT/FAMILY CARE VOLUNTEERS ONLY

DEATH AND DYING

Do you fear death?

Have you ever been with someone at the time of their death?

Have you ever been a caregiver to anyone? Yes No
If yes, please explain:

When thinking of your own death, what words best describe death to you?

- I do not think about my own death. Sorrowful Natural Frightening
 Painful Lonely Joyful Peaceful Dark

Other thoughts and feelings about death

Thank you for your interest in the Volunteer Program at Seasons Hospice. Seasons Hospice is an equal opportunity employer dedicated to a policy of non-discrimination on any basis, including race, color, creed, religion, age, sex, national origin, ancestry, sexual orientation, marital status, military status or the presence of a physical, mental, medical condition or disability.

I understand that I will be offered and be required to complete Hospice Volunteer Training. I agree to fulfill all requirements related to my role as a Volunteer with Seasons Hospice.

Signature of Applicant

Date